

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? (x) Yes () No
Requestor's Name and Address Dr. B 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-04-0734-01
	TWCC No.: _____
	Injured Employee's Name: _____
Respondent's Name and Address Texas Mutual Insurance Co. Box 54	Date of Injury: _____
	Employer's Name: _____
	Insurance Carrier's No.: 99C0000330289

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/31/02	03/19/03	99070-73	\$45.00	

PART III: REQUESTOR'S POSITION SUMMARY

Position Statement dated 09/02/03 states in part, "...Originally our charge for code 99080-73 (TWCC 73 form) was denied stating it was not legible. We resubmitted our charge showing that it was legible as required by TWCC MFG; however, the carrier again denied. We have exhausted our efforts with the carrier and we are now exercising our right according to TWCC to submit in a medical dispute for the above mentioned denial..."

PART IV: RESPONDENT'S POSITION SUMMARY

Position Statement dated 09/23/03 states in part, "...This carrier did not request additional TWCC 73 per TWCC Rule 129.5(d)(3) and the requester did not document a change in the employee's work status... This employee was UNABLE to work on 12/27/02. The employee remained UNABLE to work on 01/31/03, 03/03/03, and 03/19/03. This was NOT a significant change in the employee's work status or activity restrictions... Therefore, no reimbursement was due for the on 01/31/03, 03/03/03, or 03/19/03 TWCC-73..."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT Code 99080-73 for dates of service 01/31/03 through 03/19/03. The insurance carrier submitted original EOB denying the services as "F". Per Rule 129.5 the requestor did not show a change in the employees work status or a substantial change in activity restrictions; therefore, reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
01/31/03-							
3/19/2003	99080-73	\$45.00	\$0.00				
				Total Left Column:			\$45.00
				Total Amount Due:			\$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

Ordered by:

Marguerite Foster	12/17/04
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Authorized Signature	Typed Name	Date of Order
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PART VIII. YOUR RIGHT TO REQUEST A HEARING

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Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____